SCHUYLKILL VALLEY SCHOOL DISTRICT

Health Services

Medication Permission Form

Dear Parent/Guardian:

In order to comply with your request that we administer medication to your child during school hours and to prevent a possible error in giving medications, this permission and information form must be completed and returned to the school nurse. This applies to both prescription medication and over the counter medications. The medication must be in the original pharmaceutical container and must be properly labeled. Any changes in type or dosage of medication must be reported to the nurse. * Do not send improperly labeled bottles to school. Information on the label must include what is listed below.

Elementary School	**Middle School**	**High School**
Mrs. Erb, MSN, RN, CSN	Mrs. Oswald, LPN	Mrs. Koller, BSN, RN, CSN
serb@schuylkillvalley.org	eoswald@schuylkillvalley.org	nkoller@schuylkillvalley.org
Ph: 610-916-5728	Ph: 610-916-5587	Ph: 610-916-5486
Fax: 610-916-5048	Fax: 610-926-3321	Fax: 610-926-8341

I give my permission for the school nurse, or her designee, to give the following medication to my child during school hours:

Name of student _____Date of birth:_____

Name of medication _____

Diagnosis_____

Dosage (amount to be given) _____

Time to be administered _____

Physician's signature _____Date_____

Parent's signature _____Date: _____